IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 18, 2008

Teresa Carpenter
Preferred Community Homes Courtyard
615 Second Avenue West
Wendell, Idaho 83355

Provider #13G057

Dear Ms. Carpenter:

On **July 31, 2008,** a Complaint Survey was conducted at Preferred Community Homes Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003658

Allegation #1: There is no structure and active treatment is lacking.

Findings: An unannounced complaint investigation was conducted at the facility from 7/28/08 to 7/31/08. During that time, observations, record reviews and interviews were conducted.

During observations conducted at the facility on 7/28/08 from 3:00 - 4:00 p.m., and on 7/29/08 from 6:00 - 8:00 a.m., 11:15 a.m. - 12:10 p.m., and 1:10 - 1:45 p.m., all individuals were noted to be engaged in meaningful activities. Although some activities were completed in groups, activities appeared to be varied to individuals needs and desires.

Staff were observed to use individuals program books during the observations. Program books were reviewed and noted to contain active treatment schedules for individuals and groups, as well as training programs for activities of daily living. Staff were noted to engage individuals in meal preparation activities, meal time activities, medication administration programs, and leisure skill activities.

Additionally, six direct care staff, the QMRP (Qualified Mental Retardation Professional), the Lead Worker, the LPN (Licensed Practical Nurse) and the Administrator were interviewed. All stated active treatment schedules were in place and were being followed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: All individuals are made to sit. Staff sit on the couch and do not do anything.

Findings: An unannounced complaint investigation was conducted at the facility from 7/28/08 to 7/31/08. During that time observations and interviews were conducted.

During observations conducted at the facility on 7/28/08 from 3:00 - 4:00 p.m., and on 7/29/08 from 6:00 - 8:00 a.m., individuals were noted to be sitting on the couch with staff. Staff were noted to read to individuals from the news paper, and one individual was noted to read to his peers from a book. However, at no time were individuals noted to be forced to sit on the couch. Individuals were noted to get up from the couch and go to other areas in the facility, and staff would go with them. At no time were staff noted to be sitting on the couch and not engaged with individuals.

Staff were observed to use individuals program books during the observations. Program books were reviewed and noted to contain active treatment schedules for individuals and groups, as well as training programs for activities of daily living. Staff were noted to engage individuals in meal preparation activities, meal time activities, medication administration programs, and leisure skill activities.

Additionally, six direct care staff, the QMRP (Qualified Mental Retardation Professional), the Lead Worker, the LPN (Licensed Practical Nurse) and the Administrator were interviewed. All stated they were unaware of individuals being forced to sit on the couch. All stated they were unaware of staff sitting on the couch and not doing anything.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

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E-mail: fsb@idhw.state.id.us

August 15, 2008

Teresa Carpenter
Preferred Community Homes Courtyard
615 Second Avenue West
Wendell, Idaho 83355

RE: Preferred Community Homes Courtyard, Provider #13G057

Dear Ms. Carpenter:

This is to advise you of the findings of the Complaint survey of Preferred Community Homes Courtyard, which was conducted on July 31, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 28, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 28, 2008. If a request for informal dispute resolution is received after August 28, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

for

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MAC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Leader Matt Hauser, QMRP Common abbreviations used in this report are: LPN - Licensed Practical Nurse	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated July 31, 2008. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure staff displayed the knowledge and competence to address the health and safety needs for individuals residing in the facility. This directly impacted 2 of 8 individuals (Individuals #1 and #5) and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: 1. During an observation on 7/28/08 from 3:38 - 4:16 p.m., Individuals #1 and #5 went for a walk to a local park with one staff. Individual #1 was noted to be wearing a helmet with a full plastic face shield to protect him during falls related to a seizure disorder. The weather during the walk was noted to be hot and sunny, and the individuals were noted to walk on an asphalt road that had no sidewalk and little shade. No water or fluids were offered to the individuals during the walk to the park. The park was over 0.4 miles	W 192	**W 192 483.430(e)(2)** **STAFF TRAINING PROGRAM** The facility RN will conduct A annual in-service on knowledge and competence of the health and safety needs of all clients residing at Courtyard. The LPN will conduct quarterly in-services with all staff on health and safety issues. All new employee's will be in-serviced With-in 30 days of starting employment. The in-service will Include seizure training, hydration, clients wearing helmets, preventive And general healthcare, and Precautions to have in place When the temperature is above 90 degrees, and clients are outside and on walks. A thermometer will be placed at Courtyard to ensure that staff are	

RECEIVED
AUG 25 2008
FACILITY STANDARD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Carpenter | TITLE: Admin. | (X6) DATE: 8/22/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/31/2008

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PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

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W 192	Continued From page 1 from the facility. While at the park the individuals were noted to be in the sun and not the shade. The individuals were not offered water or fluids while at the park. The individuals remained at the park for 9 minutes. Upon returning to the facility Individuals #1 and #5 were noted to be flushed and sweating heavily. Staff offered water to Individuals #1 and #5 upon returning to the facility. Individual #1's helmet was removed upon returning to the facility. Individual #1's hair was wet with sweat, and his ears were noted to be bright red. There was no thermometer measuring outside temperature noted at the facility. During an observation on 7/29/08 from 1:10 - 1:45 p.m., five staff were present in the facility and provided the following information: The staff noted to be working with Individual #1 during the 7/28/08 walk stated she had been through a CPR (Cardio Pulmonary Resuscitation) class and had read through documentation of individuals' seizures. The staff stated she had also watched the LPN respond to individuals' seizures by talking to the individual, rubbing her hand over their heart, and asking if they were okay. The staff stated seizures could be caused by flashing lights, and for Individual #1 anything could cause a seizure. The staff stated she had not received any additional training specific to Individual #1 and his seizure disorder. The remaining four staff present stated they had not received specific training with regards to	W 192	aware of the temperature outside. The in-services will address the impact of weather conditions on all clients living at Courtyard. The In-services will be tracked on a training log to ensure that training is kept Up-dated and all training notes will be kept in a in-service training folder in the Administrator's office. All clients residing at Courtyard will be given a water bottle to be carried with them when they are out on walks, and/or on outside activities and the temp. is above 90 degrees. A protocol will Be put in place for when the temp. is over 90 degrees. Training will be conducted Quarterly to ensure that This deficient will not recur. To be completed by the RN, LPN,RSC, QMRP, and the Administrator. To be completed by 9/21/08.	

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W 192	Continued From page 2 Individual #1's seizure disorder. When asked during an interview on 7/31/08 from 10:10 - 10:35 a.m., the LPN stated she had trained staff to watch for seizures and to protect individuals during seizures. During the exit conference, on 7/31/08 at 4:30 p.m., the Administrator provided the survey team with the facility's staff training records for the previous 12 months. An Inservice Training/Meeting Sign-In Sheet, dated 4/10/08, was attached to a sheet which stated "seizures(what [sic] to watch for and what to do) -[LPN's name]." No additional information was present with regards to seizure training. The facility failed to ensure staff received sufficient training regarding individuals' seizure disorders. Additionally, the five staff present, during the observation on 7/29/08 from 1:10 - 1:45 p.m., provided the following information: When asked how staff determined the temperature before taking individuals for walks, three of the staff stated they looked at the newspaper for the forecasted temperature, but did not have a way to check what the temperature actually was at the time of a walk. All five staff stated they were unaware of written guidelines or protocols regarding heat and going for walks with individuals. When asked during an interview on 7/31/08 from 10:10 - 10:35 a.m., the Administrator stated there were no current guidelines for staff with regards to weather conditions and individuals walking outside. The Administrator provided surveyors	W 192		

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W 192	Continued From page 3 with a web-site printout which stated the temperature on 7/28/08 was 88 degrees. During the exit conference, on 7/31/08 at 4:30 p.m., the Administrator provided the survey team with the facility's staff training records for the previous 12 months. None of the training notes addressed the impact of weather conditions on individuals' health. The facility failed to ensure staff received sufficient training regarding the impact weather conditions may have on individuals outdoor activities.	W 192		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure staff provided appropriate preventative health care to 2 of 2 individuals (Individual #1) observed in the community. This failure resulted in the potential for individuals to experience negative impact on their health. The findings include: 1. During an observation on 7/28/08 from 3:38 - 4:16 p.m., Individuals #1 and #5 went for a walk to a local park with one staff. The weather during the walk was noted to be hot and sunny, and the individuals were noted to walk on an asphalt road that had no sidewalk and little shade. Individual #1 was noted to be wearing a helmet with a full plastic face shield for protection during seizure	W 322	**W 322 483.460(a)(3) PHYSICIAN SERVICES** Please refer to W 192.	

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W 322	Continued From page 4 related falls. At 3:40 p.m., Individuals #1 and #5 were walking with the staff. The staff was holding Individual #1's hand while Individual #5 walked without assistance. At 3:45 p.m., Individual #1 was observed to stagger and lean into the staff member. The staff member asked Individual #1 if he was tired. At 3:50 p.m., Individual #1 was observed to be dragging his feet. The staff and the two individuals came to an intersection at the highway that ran through the center of town. The intersection had no traffic signal. The staff member held the individuals' hands until traffic cleared and walked the individuals across the highway. A crosswalk with a traffic signal was noted to be one block away from where the staff and the individuals crossed the highway to the park. The park was noted to be over 0.4 miles from the facility. At 3:55 p.m., Individual #5 began to play on a stack of tires which were in a shadeless area of the park. Staff walked, holding Individual #1's hand, to the the area in which Individual #5 was playing on the tires. At 4:00 p.m., Individual #5 was hanging on the monkey bars which were located in an unshaded area of the park. Staff walked, holding Individual #1's hand, to the the area in which Individual #5 was playing on the monkey bars. No water or fluids were noted to be available or offered to Individuals #1 and #5 at any time while on the walk to the park or while at the park.	W 322		

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W 322	Continued From page 5 At 4:04 p.m., the staff and Individuals #1 and #5 left the park and began walking back toward the facility, crossing the highway at an unmarked crossing area. The staff walked with the individuals down the unshaded side of the street. At 4:16 p.m., the staff and the individuals arrived back at the facility. Individual #5's face was flushed, and he was noted to be sweating profusely and breathing hard. Individual #1 was directed to sit at the dining table and his helmet was removed by the staff. Individual #1's ears were noted to be bright red, and his hair was noted to be wet with sweat, which was dripping from his face. Individuals #1 and #5 were given water to drink. Individual #1 was noted to repeatedly lean his head back and staff would verbally direct him to drink water. At 4:20 p.m., Individual #5's face was still flushed and staff were noted to wipe sweat from his face with a tissue. On 7/28/08 at 5:19 p.m., the staff who went on the walk with Individuals #1 and #5 stated "I'm still hot from that walk." During an observation on 7/29/08 from 1:10 - 1:45 p.m., five staff were present in the facility, including the staff observed walking with Individuals #1 and #5 on 7/28/08. When asked how staff determined the temperature before taking individuals for walks, three of the staff stated they looked at the newspaper for the forecasted temperature, but did not have a way to check the actual temperature at the time they went for walks. All five staff stated they were unaware of written guidelines regarding heat and	W 322		

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W 322	Continued From page 6 going for walks with individuals. When asked during an interview on 7/31/08 from 10:10 - 10:35 a.m., the Administrator stated there were no current written guidelines for staff with regards to weather conditions and individuals walking outside. The Administrator provided surveyors with a printout from a web-site that stated the temperature on 7/28/08 was 88 degrees. The facility failed to ensure protocols were in place to address individuals needs in relation to weather conditions and outside activities.	W 322		
W 382	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all drugs were maintained under locked conditions for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a medication. The findings include: 1. During an observation on 7/29/08 from 6:30 - 8:00 a.m., the following items were noted to be unlocked on the counter in the medication room: - A box of Individual #2's Ibuprofen (a nonsteroidal anti-inflammatory drug) 400 mg suppositories. One suppository remained in the box.	W 382	**W 382 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING** A checklist will be made for the back up med counter to check off that all drugs and bioligicals will be locked. The checklist will be done daily at all medication times and put in the administrators box nightly. A monthly observation will also be done and recorded, this will be done to ensure this deficient will not recur. To be completed by back up Med counter, the RSC, LPN, and The Administrator by 09/21/08.	

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W 382	Continued From page 7 - Two tubes of triple antibiotic ointment. At 7:55 a.m., the LPN who was present during the interview, stated the suppositories and ointments should have been locked up. The LPN stated she believed staff had left the noted items on the counter because the items were almost empty and needed to be replaced. The LPN removed the items from the medication room. The facility failed to ensure all drugs and biologicals were kept locked.	W 382		

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PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

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MM621	16.03.11.230.05(c) Training Training in the ability to detect signs of illness or dysfunction that warrant medical or nursing referral and intervention; and This Rule is not met as evidenced by: Refer to W192	MM621	MM621 16.03.11230.05(c) TRAINING Refer to W 192	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322	MM735	MM735 16.03.11.270.02 HEALTH SERVICES Refer to W 192	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382	MM753	MM753 16.03.11.270.02(f)(i) LOCKED AREA Refer to W 382	

Bureau of Facility Standards

Teresa Carpenter — Admin — 8/22/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE